# Enactive Psychiatry: Old Wine, New Bottle —or a Better Vessel?

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*A historical and clinical test of novelty*

*Enactive psychiatry presents itself as a solution to psychiatry's integration problem: how physiological, experiential, social, and existential processes can belong to one coherent account of mental disorder. This essay argues that much of its conceptual material has identifiable predecessors in systems theory, phenomenology, philosophical anthropology, and the Dutch anthropological-psychiatric tradition. That historical continuity does not by itself invalidate the approach. The decisive question is more demanding: does enactivism translate inherited intuitions into a clearer explanatory framework and a clinically different way of observing, formulating, and treating a patient?*

## The recurring integration problem

Psychiatry repeatedly confronts the same difficulty. A mental disorder may be described as a disturbance of the brain, a pattern of experience and action, a biographical development, a social predicament, or some combination of these. The problem is not merely to acknowledge that all these dimensions matter. It is to explain how they belong together without reducing one to another or leaving them as parallel descriptions.

Sanneke de Haan formulates this as psychiatry's "integration problem." The biopsychosocial model rightly resists neuroreductionism, but it does not, in her account, adequately explain how physiological, psychological, and social processes causally interact. Her enactive alternative begins with the embodied person interacting with a material and social world. Body, experience, and environment are not separate domains connected by bridges; they are different "excerpts" of one complex, dynamical person-in-the-world system (de Haan, 2020).

The proposal is attractive because it does more than add further factors to a list. It changes the proposed unit of analysis. Instead of locating the disorder solely in the brain, the psyche, or society, it locates it in recurrent patterns of sense-making enacted by a bodily person in a world. Psychiatric disorders are accordingly described as structurally disordered or "stuck" patterns of sense-making: once adaptive ways of responding that have become inflexible and insufficiently attuned to the present situation.

## What enactivism genuinely adds

Any historical critique should first state the strongest version of the contemporary position. Enactivism does not merely repeat that the patient is a whole person. It attempts to explain why the physiological, experiential, and social dimensions are mutually dependent. Its life–mind continuity thesis holds that living already entails a basic evaluative relation to the environment: an organism must distinguish what sustains it from what threatens it. Human beings add reflexive or existential sense-making—the capacity to relate to their own experiences, histories, values, and anticipated futures.

It is worth naming precisely what kind of claim this is. The life–mind continuity thesis is, in the first instance, not a claim about efficient causation but a naturalized version of final causation—closer to Hans

Jonas's account of organic "needful freedom," whereby a metabolizing organism is intrinsically oriented toward its own self-maintenance, than to a mechanism specifying how one event brings about another. Existential sense-making, on this reading, is what happens when that self-directed orientation folds back onto itself: a human being does not merely act for the sake of self-maintenance, as an organism implicitly does, but can ask whether that self-maintenance is worth the trouble. Making this Aristotelian structure explicit clarifies both what is being claimed and what still needs separate support: a teleological framework of this kind can motivate why sense-making matters to a living system without thereby supplying the efficient-causal architecture connecting a given physiological state to a given experience—a separate task that organizational causality, examined below, is left to shoulder.

De Haan also replaces exclusively linear causation with organizational or mereological causation. A change in a part changes the organization of the whole, while changes at the level of the whole imply changes in its parts. Medication and psychotherapy may both reduce anxiety, but they travel along different causal trajectories within the same person-world system. This is the central theoretical promise: not an additional eclectic list of causes, but an account of their organized interdependence (de Haan, 2020, pp. 3–6).

This move deserves closer scrutiny than it is usually given. De Haan's own illustration elsewhere—ingredients combining in a cake, where the whole is not caused by its parts in an external, billiard-ball sense but constituted by them—works cleanly for phenomena of one ontological order: sugar and cake-flavour are both configurations of matter. The person-world system she wants to unify, however, spans physiological and experiential description, and it is precisely the relation between these two orders that the mind–body problem concerns. Redescribing serotonin levels and mood as "excerpts" of one system at different scales illuminates known local-to-global and global-to-local correlations—dose-response effects, the physiological traces of a calming conversation—but it does not thereby show that experience and physiology are excerpts of one system rather than two systematically correlated, yet distinct, kinds of fact. The analogy is persuasive partly because it quietly assumes the identity it needs to establish. This does not collapse the enactive account, but it suggests that organizational causality functions here more as a redescription that dissolves the vocabulary of separate "domains" than as an argument that closes the explanatory gap Engel left open.

This is a real conceptual refinement. The language of autonomy, adaptivity, dynamical systems, embodiment, and organizational causality gives contemporary enactivism resources that earlier philosophical psychiatry often lacked. The historical question is therefore not whether every ingredient is unprecedented, but whether the new synthesis is more explicit, disciplined, and operational than its predecessors.

## An older intellectual genealogy

### From Jaspers' phenomenology to anthropological psychiatry

Karl Jaspers' phenomenology was primarily a method of disciplined description. It asked the psychiatrist to clarify the form and structure of a patient's experience before imposing a causal theory. In obsessive-compulsive phenomena, for example, the clinician would distinguish the intrusive thought, the patient's recognition of its irrationality, the felt compulsion, the resistance, and the resulting action. Jaspers' restraint was methodological: describe and understand as far as possible, but do not turn every description into a comprehensive theory of the human being.

Ludwig Binswanger and Viktor von Gebsattel moved further toward philosophical anthropology. Their question was not only how an experience is structured, but how a person's mode of being-in-the-world has altered. Von Gebsattel's analyses of compulsion focused on disturbances of temporality, becoming, and

the person's capacity to move forward. The symptom was not merely an isolated mental event; it expressed a more pervasive transformation of the person-world relation.

That difference matters historically. Jaspers supplied a descriptive discipline; anthropological psychiatry supplied a more ambitious interpretation of personhood, values, embodiment, temporality, and world-relation. In practice the two could overlap. A careful clinician may both describe an obsession precisely and ask how a world has become so unreliable that repeated checking appears necessary. Yet their epistemic ambitions remained different.

### The Dutch anthropological tradition

Dutch anthropological psychiatry and medicine developed a comparable protest against the reduced human image. Lammert van der Horst argued for an integrated conception of the patient as a bodily, psychological, social, and spiritual unity. Communication and the physician–patient encounter were not secondary additions to medicine but belonged to the constitution of clinical understanding. J. J. G. Prick later described physical stimuli as becoming meaningful only within the lived valuation of the concrete individual—an awkwardly expressed but recognizably relational account of meaning.

These formulations anticipate several themes now associated with enactivism: the rejection of an isolated inner mind, the inseparability of experience and environment, the constitutive role of interaction, and the claim that meaning is not simply contained in a stimulus. They also reveal a weakness. The tradition frequently generated a rich philosophical vocabulary without specifying how it should alter diagnosis, treatment selection, or outcome measurement. Its language could illuminate, but it could also bury a simple clinical observation under several layers of terminology.

## Old wine? The charge needs refinement

It is therefore too simple to say that enactive psychiatry is merely old wine in a new bottle. Intellectual inheritance is not the same as redundancy. Medicine routinely advances by reformulating older observations within a more coherent model. The proper comparison has at least three levels: the originating intuition, the explanatory machinery, and the clinical consequences.

At the level of intuition, the continuity is substantial. Jakob von Uexküll's Umwelt, Heidegger's being-in-the-world, Merleau-Ponty's embodied perception, von Weizsäcker's Gestaltkreis, Jaspers' phenomenological method, and anthropological psychiatry all resisted a passive, context-free model of mind. Varela, Thompson, and Rosch's language of enaction and sense-making belongs to this genealogy rather than appearing ex nihilo.

At the level of explanatory machinery, enactivism is more distinctive. Autopoiesis and autonomy attempt to ground normativity in the organization of living systems. Dynamical-systems concepts are intended to replace static lists of factors with histories of mutually reinforcing patterns. Organizational causality attempts to show how local physiological processes and global experiential or social patterns can belong to one system without being identical.

At the level of clinical consequences, however, the case remains less established. De Haan's 2020 paper argues that the model should influence research questions, treatment decisions, communication, and interdisciplinary cooperation. It does not present evidence that enactive case formulation improves diagnostic reliability, treatment selection, adherence, therapeutic alliance, or outcomes compared with existing biopsychosocial or formulation-based practice. That is not a refutation; it identifies the empirical burden the theory still has to meet.

## The clinical test: what changes in the consulting room?

The most useful test is deliberately severe: after reading the theory, does the clinician see, ask, formulate, or do anything differently? A conceptual framework earns clinical importance when it produces discriminating observations or decisions, not merely a more attractive vocabulary.

Consider a patient with obsessive-compulsive disorder who repeatedly returns home to check whether the door is locked. A descriptive phenomenology asks: What exactly intrudes? How certain or uncertain does the patient feel? Does the thought appear as their own? How do resistance, responsibility, anxiety, and relief unfold? An anthropological analysis asks how the patient's world has changed: how the ordinary trustworthiness of action, memory, time, and responsibility has collapsed into an existence organized around preventing catastrophe.

An enactively informed formulation would add a developmental and dynamical question. Through repeated checking, short-term relief and environmental feedback stabilize a particular pattern of sense-making. Door, memory, bodily anxiety, imagined responsibility, family accommodation, and checking behavior become mutually reinforcing components of one person-world system. Treatment aims not merely to remove a thought but to perturb and reorganize the pattern—for example through exposure and response prevention, changes in accommodation, attention to bodily arousal, and a shared formulation of how the cycle sustains itself.

It is worth being explicit about the comparison class here. The formulation just sketched—door, memory, bodily anxiety, imagined responsibility, family accommodation, and checking behaviour as mutually reinforcing components of one system—is difficult to distinguish from the standard "four P's" biopsychosocial formulation (predisposing, precipitating, perpetuating, and protective factors) already taught in psychiatric training, combined with an ordinary cognitive-behavioural maintenance-cycle diagram. Both already treat the presenting problem as sustained by a loop spanning cognition, behaviour, physiology, and environment, without invoking sense-making, autopoiesis, or mereological causality to do so.

Yet the critical issue remains: is this clinically different from a sophisticated cognitive-behavioral formulation combined with phenomenological attentiveness? It may be. Enactivism could prevent the therapist from treating the obsession as an isolated faulty proposition and could make interpersonal and environmental processes integral rather than adjunctive. But this difference must be demonstrated in concrete formulations, treatment choices, and outcomes. Otherwise the enactively informed psychiatrist risks behaving exactly like an already competent, pluralistic clinician.

## Narrative and relational value are not trivial

Even if enactive psychiatry does not produce a new treatment algorithm, its clinical value need not be negligible. A coherent explanation can alter how a patient understands a disorder, reduce the split between "my brain" and "myself," and support shared decision-making. It can also discipline empathy: not empathy as benevolent feeling, but as an effort to understand how a particular world has acquired its present structure of relevance.

This may be where the continuity with Rümke, van der Horst, and the older phenomenological tradition is most productive. The therapeutic relationship is not merely a channel through which a technical intervention is delivered. It may itself modify the patient's possibilities for sense-making and action. That proposition is clinically plausible, but again it should be formulated as a hypothesis rather than assumed as a historical truth.

Rümke's praecox-Gefühl is an instructive precedent here: a trained, largely pre-reflective sense by which an experienced clinician recognized incipient schizophrenia in the clinical encounter, decades before

enactivist vocabulary existed. It illustrates that clinical attunement of this kind is a real and transmissible skill—but also that enactivism has not yet shown it can teach or measure this skill any more reliably than the older phenomenological tradition did.

## Why the older schools faded

The disappearance of phenomenological, psychoanalytic, and anthropological psychiatry from the mainstream cannot be explained by a single intellectual defeat. Their decline coincided with the success of psychopharmacology, the demand for diagnostic reliability, the rise of DSM-III, quantitative research, randomized trials, and institutional pressures favoring methods that could be standardized, taught, funded, and audited.

The older schools also contributed to their own marginalization. Their concepts were often difficult to delimit; rival interpretations were hard to adjudicate; and clinical consequences remained underspecified. Philosophical richness could become terminological inflation. A theory that claims to restore the whole person but cannot show what the psychiatrist should observe or decide differently is vulnerable when confronted by approaches offering reproducible categories and measurable outcomes.

Enactive psychiatry should therefore be judged partly by whether it avoids this historical fate. Can it retain the older schools' attention to lived experience without reproducing their methodological vagueness? Can it connect person-world descriptions to testable hypotheses without reducing them to symptom counts? Can it explain why one intervention is preferable to another for a particular patient? These questions matter more than whether its vocabulary is historically novel.

## A more defensible conclusion

Enactive psychiatry is neither a wholly new invention nor a mere act of conceptual relabelling. It is better understood as a contemporary reconstruction of a long anti-reductionist lineage. Its strongest contribution is the attempt to place phenomenological and anthropological insights within a biologically grounded, dynamical account of embodied sense-making.

Its weakness is presently clinical underdetermination. The framework explains why multiple levels and forms of intervention may matter, but it does not yet clearly establish when an enactive formulation outperforms an excellent biopsychosocial, phenomenological, or cognitive-behavioral formulation. The decisive research programme is therefore comparative and operational: specify the observations, decisions, and predicted outcomes that are uniquely enabled by the enactive account.

Old wine, certainly—but perhaps not merely a new label. The more interesting possibility is that enactivism offers a better vessel: one capable of preserving insights that earlier psychiatry could describe eloquently but could not adequately organize or test. Whether the vessel improves what reaches the patient remains the question on which the theory should stand or fall.

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